EXHIBIT "B"

YOU & KODAK

Employee Handbook

We are pleased to provide you with the latest edition of the "You & Kodak Employee Handbook." This handbook provides a comprehensive picture of your benefits as well as Kodak's human resources policies and principles. The handbook is divided into three key sections:

1. **THE COMPANY & YOU** – This section contains the Human Resources Policies and Principles that apply to your employment with Eastman Kodak Company. Basic principles, such as respect, fairness, trust, accountability, and open communications are reflected in these policies and principles. Applied daily, they provide a solid foundation upon which to build our future.

2. **BENEFIT SUMMARIES** – This section contains the employee benefit plans sponsored by Eastman Kodak Company. The section is categorized as follows:
   - **Security for Today**—Includes summaries for Flex Program benefits as well as for short- and long-term disability, and other income protection plans.
   - **Planning for the Future**—Includes summaries for KRIP, SIP, KESOP, Wage Dividend and Other Investments.
   - **Balancing Work & Life**—Includes summaries for Holiday, Vacation, Leaves of Absence, Adoption Assistance and Employee Assistance.

   Each summary provides information about who is eligible to participate in the plan to which it pertains, who pays for plan coverage, what benefits are provided under the plan, and how participants can get those benefits. Because many of the terms appearing in this section of the handbook have a special meaning when used with respect to the benefit plans, a "Glossary Of Terms" is provided at the beginning of this section for your convenience.

3. **LIFE EVENT SUMMARIES** – The benefits you receive from the Company are designed to help and support you during the different times of your life – from the beginning of your career forward. These summaries will help you determine what, if any, changes you can make to the numerous benefits available to you when life events such as marriage or divorce, birth or adoption, disability, and changes in employment status occur.

Please keep this handbook and refer to it first when you have questions concerning human resources policies or your company benefits. Use the table of contents starting on the next page to help you locate the information you need. If you still have questions, don't hesitate to call any of the information resources listed in the "Who to Contact" section in the back of this handbook.

If you have access to a computer, you may prefer to use the on-line version of this handbook located on the Company's Total Compensation website at totalcomp.kodak.com.

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* Note: The complete text of the asterisked policies is available on Eastman Kodak Company's Policies & Procedures Website at: policies.kodak.com

ABOUT THIS HANDBOOK

This handbook only provides a summary of Kodak's Human Resources policies and principles and of the employee benefits available to eligible Kodak employees.

All statements contained in the section of this handbook describing the Company's Human Resources policies and principles are intended to reflect general policies, principles and procedures. They do not represent a contractual commitment on the part of the Company and may be changed at any time without notice. Since no policy, principle or procedure is appropriate for every possible situation that may arise, Kodak may choose not to apply a particular policy, principle, or procedure (or a part of one) as it deems appropriate based upon its assessment of a particular set of facts.

The information contained in the sections of this handbook containing the benefit summaries and life event summaries is intended to provide an overview of the terms and conditions contained in the formal documents governing the Company's benefit plans (often referred to as the "plan documents"). These sections do not contain the complete text of each plan document and, while every attempt has been made to be as accurate as possible, they do not include the full details of all provisions contained in each plan document. If a summary's provision differs from the provision written in the applicable plan document, the plan document serves as the final authority. Similarly, any oral or written representations by a company employee or agent, or any benefit estimates that you may receive, cannot override, reverse or supplement the provisions of the plan documents.

IMPORTANT STATEMENT REGARDING YOUR BENEFITS

You, your survivors or any other person who claims entitlement to the benefits described in this handbook cannot rely on any oral or written statement from any person (including, without limitation, officers and employees of Kodak, a Kodak subsidiary or agent, an insurance carrier, a claims administrator or a recordkeeper) with respect to any aspect of your benefits. You must read the applicable summaries and plan documents (see the "Plan Documents" section of the "General Plan Information" summary for directions on how to access plan documents) to determine your benefits. The provisions of the plan documents govern over any inconsistent benefit information given to you orally or in writing, regardless of the source.

HANDBOOK DISTRIBUTION

This handbook is published for eligible U.S. employees of Eastman Kodak Company and participating affiliates as of January 1, 2002. Note that *your eligibility for any Kodak benefit plan is not established by your receiving this handbook.* Your participation depends upon having qualified under the specific plan provisions, or, in some cases, upon your voluntary participation.

This handbook does not apply to individuals who retired, began receiving long-term disability benefits or became a survivor, on or before January 1, 2002.

Procedures for Plan Claims and Appeals

This benefit summary regularly uses several terms that have very specific meanings. These terms are defined either in the "Glossary Of Terms" provided earlier in this handbook or in the part of this summary where they apply. Defined terms may or may not be capitalized, or may be singular or plural, when they are used.

INTRODUCTION

This summary describes the procedures used to process claims and appeals pertaining to the benefit plans described in this handbook. These procedures are to be followed before judicial review of a denied claim can be sought.

The plan administrator of a plan generally has decision-making authority with respect to that plan's claims and appeals. The plan administrator's authority is fully discretionary in all matters related to the discharge of his or her responsibilities and the exercise of his or her authority under the Plan including, without limitation, his or her construction of the terms of the plan and his or her determination of eligibility for coverage and benefits. Under some plans, the plan administrator delegated his or her authority to a claims administrator or another person or entity. In this summary, the term "claims reviewer" is used to refer to the plan administrator or other person or entity with decision-making authority under a plan with respect to that plan's claims and appeals.

It is the intent of each plan that the decisions of the plan administrator (or the party to whom the decision-making authority was delegated), and his or her actions with respect to the plan, will be conclusive and binding upon all persons having or claiming to have any right or interest in or under the plan, and that no such decision or action will be modified upon judicial review unless such decision or action is proven to be arbitrary or capricious.

The plan administrator for all benefit plans except those listed below is the Director, Worldwide Benefits, Eastman Kodak Company, 343 State Street, Rochester, N.Y. 14650-1112 (telephone number: 585-724-4800):

Benefit Plan	Plan Administrator
Kodak Retirement Income Plan	Kodak Retirement Income Plan Committee (KRIPCO)
Eastman Kodak Employees' Savings and Investment Plan	Savings and Investment Plan Committee (SIPCO)
Kodak Employee Stock Ownership Plan	Stock Ownership Plan Committee (SOPCO)

Communications with the above committees should be addressed in care of the Director, Worldwide Benefits, at the above address.

FILING CLAIMS

Under each of the Kodak benefit plans, a claims procedure must be followed by the claimant in order to receive benefits. In this summary, the "claimant" may be you, one of your covered Dependents, or your beneficiary, depending on the plan.

Under the Kodak Medical Assistance Plan, KRx, Kdent and LTC, the claimant should complete the appropriate claim form, attach the required supporting documentation, and mail it to the appropriate claims processing unit as noted in the "Claims And Payment Of Benefits" portion of the applicable plan's benefit summary. Be sure to check time limits that might apply since a claim may be denied if it is submitted after the time limit for filing has expired. In some cases, the claimant's physician or a hospital may "file" the claim for him or her by billing the carrier or other claims reviewer directly.

To use the EAP, you should contact the EAP office to make an appointment as described in the plan's benefit summary.

In the case of life insurance (other than accidental death covered under AD&D and Dependent AD&D) and OAD, Metropolitan Life Insurance Company (MetLife) will send your beneficiary a letter and self-explanatory forms to be completed and returned. Continental Casualty Company (CNA) will send a letter and forms to your beneficiary in the case of accidental death covered under AD&D and to you in the case of accidental death under Dependent AD&D. When completed and returned, these forms constitute a claim for benefits.

In the event you or your dependent suffer an injury that is covered under AD&D or Dependent AD&D, you can submit a claim to CNA as noted under "Claims And Payment Of Benefits" in the AD&D and Dependent AD&D summaries.

When you leave the Company for any reason (except death), you will have to contact the SIP-Line to request distribution of any funds you have in SIP and T. Rowe Price to request distribution of any funds you may have in KESOP. You also must complete the appropriate forms for the eventual distribution of any retirement income benefit you may receive under KRIP. If you are planning on retiring, you should plan to notify the Kodak Benefits Center at least 60 days before the date you wish your retirement to become effective.

If you wish to apply for LTD benefits, you should apply when you receive notification from the Kodak Benefits Center that your STD or WCS benefits will be exhausting. You should also contact the Kodak Benefits Center to apply for LTD benefits if you are laid off while on STD or WCS and your benefits under that plan will be ending.

You should read the claims information in each of the benefit summaries contained in this handbook so that you can file claims properly. You may wish to look under "Claims And Payment Of Benefits" in the separate summaries for the Kodak Medical Assistance Plan, KRx, Kdent, HCRA, DCRA, KLifePlus, Dependent LifePlus, AD&D, Dependent AD&D, LTD Plan, LTC, Vacation Buy, KRIP, SIP, KESOP, the STD Plan, the WCS Plan, OAD and EAP. For life insurance, AD&D and OAD you should also check the heading "Beneficiaries And Assignments" in those summaries. For KRIP and KESOP, you should also check "Survivor Benefits" and, for SIP, you should also check "Payments To Beneficiaries."

Claimant's Use Of Authorized Representatives: You, your covered Dependent or your beneficiary can designate an authorized representative to act on behalf of you, your Dependent or your beneficiary in connection with the submission or processing of plan claims. If the claimant is a child, the child's parents will automatically be considered the child's authorized representative unless the claims reviewer is advised otherwise in writing. If a claimant's authorized representative is someone other than the persons automatically considered to be authorized, the claimant and authorized representative may be required to provide the claims reviewer with a signed statement describing the designation. An assignment of benefits by a claimant does not by itself function as an authorized representative designation.

Written designation of an authorized representative is necessary to protect against disclosure of information about the claimant except to his or her authorized representative. When a claimant has an authorized representative, all notices and other communications pertaining to the claimant's claim will be furnished to the authorized representative only unless the claimant makes a written request to the claims reviewer that a copy of all notices and other communications be sent to him or her.

INITIAL CLAIM DETERMINATIONS

If your claim is for health care or LTC benefits, the claim will be processed according to the procedures described in your benefits booklet or, if no benefits booklet is in effect when the claim is filed, according to the procedures described below.[1] If your claim is for any other benefits, the procedures described below will govern how the claim is processed.

If you have questions about any notice you receive regarding the payment or nonpayment of your claim, you should contact the claims reviewer to whom the claim was submitted (for example, the plan administrator, insurance carrier or other claims administrator), since there may be a simple solution to your problem.

Regarding Non-Disability Claims: If your claim is for benefits other than disability benefits, the claims reviewer with whom your claim was filed has to make a decision whether to approve or deny the claim within a reasonable period of time, not to exceed 90 days following the reviewer's receipt of the claim. In special situations, an extension for an additional 90 days may be required to process the claim. In such a case, written notice of an extension will be furnished within the original 90-day period, explaining the reason for the delay and the date by which a decision can be expected.

If your claim is approved by the claims reviewer, payment of the claim will be made as described under the "Claims And Payment Of Benefits" part in the applicable plan's benefit summary.

If your claim is denied by the claims reviewer, you will receive written or electronic notification from the claims reviewer of the specific reason or reasons for the denial. The notice will also include specific reference to applicable plan provisions on which the denial was based, a description of any additional information needed to complete the claim with an explanation of why it is necessary, instructions to be followed if you wish to appeal the denial, and a statement about your right to bring a civil suit under ERISA following the appeal. The denial notice will be mailed within 90 days of the claim's filing unless the 90-day processing extension applied to the claim. In that case, the denial notice will be mailed within 180 days of the claim's filing.

If you do not receive notice of a decision or an extension notice within 90 days of filing your claim, you should assume that your claim has been denied. If you receive an extension notice, but you do not receive notice of a decision within 180 days of filing a claim, you should assume that the claim has been denied.

Regarding Disability Claims: If your claim is for disability benefits (e.g., STD or LTD benefits), the claims reviewer has to make a decision whether to approve or deny the claim within a reasonable period of time, not to exceed 45 days following the reviewer's receipt of the claim. An extension of an additional 30 days may be taken in circumstances beyond the reviewer's control so long as written notice is given to you before the initial 45-day period expires. This notice will explain the reason(s) for the delay and the date by which a decision can be expected. If a reason for the delay involves the need for more information, you have 45 days from receipt of the extension notice to provide the needed information, and a

[1] State laws generally have special rules governing the processing of claims for insured health care benefits. These laws usually include claim determination processes similar to the procedures described in this summary. However, if a rule described in this summary is more favorable to a claimant than the rule under state law, this summary's rule may supercede the rule required by state law. As a result, the rules used to process an insured health care claim should be determined at the time that the claim is filed.

determination will then be made within 30 days after the earlier of the date that the claims reviewer receives the needed information or the end of your 45-day period to provide the information.

A second extension of an additional 30 days may be taken in circumstances beyond the claim reviewer's control so long as written notice is given to you before the first 30-day extension period expires. The notice will also explain why the delay is necessary and the date by which a decision can be expected, and if a reason for the delay involves the need for more information, you again have 45 days from receipt of the extension notice to provide the information. A determination will be made within 30 days after the earlier of the date that the claims reviewer receives the needed information or the end of your 45-day period to provide the information.

If the claim is denied, you will be given written or electronic notice of the denial. The denial notice will include the specific reason(s) for the denial, specific reference to applicable plan provisions on which the denial was based (including disclosure of any internal rule, guideline or protocol relied on in making the determination), a description of any additional information needed to complete the claim with an explanation of why it is necessary, instructions to be followed if you wish to appeal the denial, and a statement about your right to bring a civil suit under ERISA following the appeal.

If you do not receive notice of a decision or an extension notice within 45 days of filing your claim, you should assume that your claim has been denied. If you receive an extension notice, but you do not receive notice of a decision within 90 days of filing a claim, you should assume that the claim has been denied.

APPEALS

If your denied claim is for health care or LTC benefits, the claim will be processed according to the procedures described in your benefits booklet or, if no benefits booklet is in effect when the appeal is filed, according to the procedures described below.[2] If your denied claim is for any other benefits, the procedures described below will govern how the claim is processed.

How To File An Appeal: If you are not able to satisfactorily resolve a benefit claim denial with the claim reviewer, you should contact the Kodak Benefits Center. They may be able to answer questions or otherwise satisfy your concerns about the handling of the denied claim.

If you remain dissatisfied and wish to appeal your claim denial, you must write a letter (as described below) to the plan's claims reviewer authorized to review appeals:

- ***within 90 days following your receipt of the claim's denial notice (or within 90 days of the date the claim is assumed to be denied) if the claim involved is not a disability claim; or***
- ***within 180 days following your receipt of the claim's denial notice (or within 180 days of the date the disability claim is assumed to be denied) if the claim involved is a disability claim.***

No form of communication other than a letter (for example, telephone or e-mail) will constitute an appeal.

If the denied claim being appealed pertains to the following coverage, the claims reviewer authorized to review the appeal is the third-party claims administrator for the applicable plan:

- Kmed fee-for-service coverage for Rochester participants;
- All POS coverage;
- All HMO coverage;

[2] State laws generally have special rules governing the review of denied claims for insured health care benefits. These laws usually include appeal processes similar to the appeal procedures described described in this summary. However, if a rule described in this summary is more favorable to a claimant than the rule under state law, this summary's rule may supercede the rule required by state law. As a result, the rules used to appeal a denied insured health care claim should be determined at the time that the appeal is filed.

- All EPO coverage;
- KRx coverage;
- LTD coverage; and
- LTC coverage.

The claims administrator for each of these coverages is identified in the booklet describing the coverage or in the benefit summary in this handbook describing the applicable plan. Your letter to the claims administrator requesting review of a denied claim must be in the form directed by the claims administrator and include all required information. Any questions about how to file an appeal with a particular claims administrator should be addressed directly to that claims administrator.

If the denied claim being appealed pertains to the following plan benefits, an individual (currently the Director, Worldwide Benefits) has been authorized to review appeals of claims denials:

- KRIP;
- SIP; and
- KESOP.

All other benefit denials must be appealed to the plan administrator. Appeal letters should include the reasons why you believe the claim was improperly denied, as well as any other data, questions or comments you deem appropriate. Call the Kodak Benefits Center with any questions you may have about how to file an appeal and what information to include.

When you appeal a denied claim, you have the right to submit written comments, documents, records, and other information relating to the denied claim. You also can access or obtain copies of any documents, records and other information relevant to the denied claim upon request and without charge.

Appeals Of Denied Non-Disability Claims: The claims reviewer authorized to review your appeal has to make a decision whether to approve or deny the appeal within a reasonable period of time, not to exceed 60 days following the date on which the reviewer receives the written appeal. In special circumstances, however, an extension for an additional 60 days may be required for processing an appeal. In such a case, written notice of the extension will be furnished to you within the original 60-day period, explaining the reason for the delay and the date by which a decision can be expected.

In making a decision, the claim reviewer will take into account all information submitted by you that relates to your denied claim without regard to whether the information was submitted or considered when the initial claim determination was made. You will receive written or electronic notice of the claims reviewer's decision regarding the appeal. If the decision upholds the initial claim denial (that is, if an adverse determination is made on appeal), the notice will include:

- the specific reason(s) for the decision;
- specific references to the pertinent plan provisions on which the decision is based;
- a statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim;
- a statement describing any voluntary appeal procedures offered by the plan and how to obtain information about those procedures; and
- a statement about your right to start a civil suit under ERISA.

If you do not receive notice of the decision regarding your appeal within the applicable 60-day review period (or 120-day review period in the case an extension applies), you should assume that the appeal has been denied.

Appeals Of Denied Disability Claims: The claims reviewer authorized to review your appeal will be someone other than the decision maker of the initial claim determination. The claims reviewer has to make a decision about the appeal within a reasonable period of time, not to exceed 45 days following the date on which the reviewer receives the written appeal. An extension of an additional 45 days may be taken if the reviewer determines that special circumstances apply and written notice of the extension is given to you before the initial 45-day period expires. The extension notice will explain the reason(s) for the delay and the date by which a determination on review can be expected.

In making a decision, the claim reviewer will not defer to the findings and conclusions made with respect to the initial claims determination. You will receive written or electronic notice of the reviewer's decision regarding the appeal. If the decision upholds the initial claim denial (that is, if an adverse determination is made on appeal), the notice will include:

- the specific reason(s) for the adverse determination;
- specific reference to applicable plan provisions on which the decision was based (including disclosure of any internal rule, guideline or protocol relied on in making the determination);
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim;
- a statement regarding any voluntary appeal procedures offered by the plan and how to obtain information about those procedures; and
- a statement about your right to bring a civil suit under ERISA.

If you do not receive notice of the decision regarding your appeal within the applicable 45-day review period (or 90-day review period in the case where an extension applies), you should assume that the appeal has been denied.

Long-Term Disability

This benefit summary regularly uses several terms that have very specific meanings. These terms are defined either in the "Glossary Of Terms" provided earlier in this handbook, or in this summary's "Terms To Know..." section, or in the part of this summary where they apply. Defined terms may or may not be capitalized, or may be singular or plural, when they are used. Also, the rules describing which employees are eligible for the Flex Program are detailed in the applicable definitions included in the "Glossary Of Terms."

INTRODUCTION

The **Kodak Long-Term Disability Plan (LTD Plan)** is designed to provide you with continuing income when an extended disability prevents you from working. If you qualify and are approved, LTD benefits begin when your employment with the Company terminates following the exhaustion of your benefits under the STD Plan or WCS Plan. The LTD Plan covers both temporary and permanent disabilities.

LTD is designed to provide you with continuing income when an extended disability prevents you from working.

The amount of coverage you receive under either of the two available LTD coverage options is based on your IASR, which is an approximation of your annual compensation. As a Flex Plan Employee, you automatically receive coverage under the LTD1 option (55 percent of IASR) which is fully paid for by the Company. You can elect to increase your plan coverage to the LTD2 option (70 percent of IASR), subject to some limitations discussed below under "Enrollment And Effective Dates," but you cannot elect to decline plan coverage (i.e., you cannot decline coverage under the LTD1 option). The payment of benefits under either LTD coverage option is not automatic. You must apply for and be approved to receive plan benefits.

The payment of LTD benefits is not automatic. You must apply for and be approved to receive benefits.

Your LTD benefits, when combined with Social Security payments and certain other benefits (e.g., statutory disability or workers' compensation benefits) for which you may be eligible, will total the maximum monthly benefit allowed under the LTD coverage option in effect when you become disabled — either 55 percent or 70 percent of your IASR. Benefits you receive from disability insurance which you maintain personally will not affect your LTD benefits.

Claims for LTD Plan benefits are administered by MetLife.

TERMS TO KNOW BEFORE READING THIS BENEFIT SUMMARY

In addition to the terms defined in the "Glossary Of Terms" earlier in this handbook, this benefit summary regularly uses several terms that have very specific meanings. The terms that are used frequently are defined below. Other less frequently used terms are defined in the part of this summary where they apply. Defined terms may or may not be capitalized, or may be singular or plural, when they are used.

Disabled: You are Disabled when your condition meets all of the following four criteria:

- As a result of your condition, you are totally and continually unable to engage in gainful work, with or without reasonable accommodation. "Gainful work" is paid employment for which you are (or you become) reasonably qualified by education, training or experience, as determined by MetLife;
- You are under the care of a licensed physician who is treating your condition;
- Your condition has lasted 26 weeks or more, or, if your employment is terminated under TAP or a Special Separation Program (involuntary or voluntary) before 26 weeks have passed since your condition arose, MetLife determines that your condition is reasonably expected to last 26 weeks or more; and
- Your condition did not result from your participation in an insurrection, rebellion, or riot, nor did it result from commission of a crime for which you are convicted. Determination of disability status, and approval of a claim, may be delayed pending the results of an investigation or trial relating to such activities.

MetLife: MetLife refers to Metropolitan Life Insurance Company.

Plan: The Kodak Long-Term Disability Plan is at times referred to in this benefit summary as the "plan."

ELIGIBILITY

The terms used below to describe which employees are eligible for plan coverage are detailed in the applicable definitions included in the "Glossary Of Terms."

Employees: You are eligible for coverage under the LTD Plan if you are a Flex Plan Employee other than a Conditional Employee, LOA Employee or Educational LOA Employee.

LOA Employees: If you become an LOA Employee or Educational LOA Employee, your coverage under the LTD Plan is automatically discontinued on the last day of active employment before your leave of absence begins. For information on when your coverage may be reinstated, see the "Leave Of Absence" section below.

Retirees: Retirees are not eligible for LTD coverage. However, the LTD benefits of certain LTD Recipients who become Retirees may continue during retirement. For more information, see the "Pension Benefit Offset" under "Benefits" below.

ENROLLMENT AND EFFECTIVE DATES

Elections And Effective Dates: The "Kodak Flexible Benefits Program" summary describes the initial or new hire elections, annual enrollment elections and change in status elections that you are eligible to make as a Flex Plan Employee, when your elections become effective and what coverage you will have under this plan if you did not make an election in a timely manner, subject to the following special rules.

See the Flexible Benefits Program Summary for more details on electing coverage.

Annual Enrollment Elections: If you elect the LTD2 coverage option and you are required to provide proof of good health as described below, your coverage under LTD2 will not begin until the date that MetLife approves your election or the first day of the following year, whichever is later. In the meantime, your coverage under the LTD1 option will continue.

Change In Status Elections: Change in status elections must be made within 30 days following a qualifying change in status and be consistent with the qualifying change in status. Examples of events that, according to IRS rules, may be qualifying changes in status for purposes of making or changing an election pertaining to plan coverage at a time other than annual enrollment include (but are not limited to) the following:

- your marriage or the filing of an Affidavit of Domestic Partnership[1];
- your divorce or termination of your Domestic Partnership;
- birth, adoption or placement for adoption of a Dependent Child;
- a child losing or gaining Dependent status under a benefit plan of the Company or another employer; and
- a Dependent gains or loses employment with another employer.

The type of event that occurs will govern the type of change that can be made to your election. If you experience one of the above events or one similar to them, you should contact the Kodak Benefits Center to determine whether you can change your election and, if so, in what manner.

You are responsible for reporting any changes in status to the Kodak Benefits Center within 30 days following the event.

A change in status election to increase your coverage category will begin on the day your election is entered into Kodak's records. However, if your election requires that you submit "proof of good health" as described below, your increased coverage will not begin until MetLife approves it.

A change in status election to decrease your coverage will begin on the day your election is entered into Kodak's records.

Proof Of Good Health Required For Certain Coverage Increases: If you increase your coverage to the LTD2 option, you must provide proof of your good health as required by the plan. In this case, coverage under the LTD2 option will not begin until MetLife approves it. In the meantime, your coverage under the LTD1 option will continue in effect until your LTD2 coverage begins. However, if you should become Disabled after you have provided proof of good health but before MetLife approves the increased coverage, you will receive the increased benefit if MetLife would have approved the increased coverage based on the proof of good health you submitted.

No proof of good health is required if you are rehired within 30 days of the time you left the Company, your rehire date was in the same calendar year as your termination date, and you were a participant in the LTD Plan on your termination date. If you are rehired more than 30 days after you left, your rehire date is in the next calendar year, or you were not a participant in the LTD Plan on your termination date, you will automatically be covered by the LTD1 option until you can make a change in status election for LTD2. Your election will be subject to you providing proof of your good health as described above.

Actively At Work Rule: If you elect the LTD2 coverage option, that coverage begins when MetLife approves it only if you are "actively at work." If you are not actively at work on the day you make the election, coverage begins on the first day that you are actively at work for a full day. "Actively at work" means that you are not absent on account of illness or injury, you are not on leave of absence, and you are physically capable of performing your job.

COVERAGE

Coverage Options: Table I below shows the options available under this plan:

TABLE I: LTD PLAN OPTIONS

Option	Maximum Benefit While Disabled
LTD1	55 percent of IASR minus offsets
LTD2	70 percent of IASR minus offsets (minimum benefit of $100 per month)

Offsets are discussed in "Calculation of Monthly LTD Benefits" under the "Benefits" section below. Under LTD2, even if your offsets are equal to or greater than 70

[1] Refer to the definition of Domestic Partner in the "Glossary of Terms" for additional eligibility

percent of your IASR, you will receive a monthly LTD benefit of $100 (subject only to withholdings required by law and repayment of any previous overpayment), provided that you are Disabled. Note that benefits paid to you under the LTD Plan are subject to income tax.

You cannot decline coverage under the LTD Plan.

COVERAGE COSTS AND CONTRIBUTIONS

The cost of your coverage depends upon the option you elect, your age and your IASR.

As explained in the "Kodak Flexible Benefits Program" summary, the cost of your plan coverage depends upon the option you elect, your age and your IASR. The coverage costs for the various options are set by Kodak each year.

The age used to calculate your annual coverage cost is your age as of December 31 of the previous year.

The IASR used to calculate your annual coverage cost is your IASR as of the later of:

- July 1 of the previous year[2] (usual case);
- the last date you were reclassified from part-time to full-time or from full-time to part-time status; or
- your hire date or the date you transfer to Flex Plan Employee status.

Table II below lists the coverage cost factors for various age groups.

TABLE II: COVERAGE COST FACTORS BY AGE GROUP

Annual Coverage Cost Factors

Age	LTD1	LTD2
Under 35	.00122	.00201
35-39	.00151	.00252
40-44	.00183	.00305
45-49	.00266	.00439
50-54	.00395	.00649
55-59	.00520	.00855
60-64	.00367	.00608
65 and over	.00424	.00704

Your annual coverage cost is calculated by multiplying your IASR by the annual coverage cost factor from Table II which corresponds to your age on December 31 before the plan year begins, and rounding the result to the nearest dollar.

Example: If you have been a Full-Time Employee since the previous July 1 when your IASR was $27,500, you are age 41 on December 31 before the next plan year begins, and you elect the LTD2 option for the next plan year, your annual coverage cost for the next plan year is: ($27,500 x .00305) = $83.88, rounded to $84.

Company Contributions: The company contributions provided under the plan equal the coverage cost for the LTD1 option.

The company contributions under the plan equal the coverage cost for the LTD1 option.

Paying for Your Coverage: Election of the LTD2 option will require that pre-tax salary contributions be deducted from your paychecks as provided in the "Kodak Flexible Benefits Program" summary. Your deductions will be in approximately equal amounts throughout the year.

The enrollment communications you receive each year specify the actual bi-weekly salary contribution amount that will be payable for your plan election. This amount represents the difference between the annual coverage cost for LTD2 and your company contributions for that option, divided by 26.

[2] You must be employed on January 1 of a year for your new IASR to take effect.

BENEFITS

Initial Eligibility For Benefits: To qualify for LTD Plan benefits, you must apply for the benefits and be Disabled while plan coverage is in effect.

Benefit Eligibility Date: If you are Disabled and apply for plan benefits, you become eligible for LTD benefits beginning on the day immediately following the date on which your employment terminates following the **later** of:

- the day on which your benefits (other than state-mandated disability benefits) under the STD Plan or WCS Plan are exhausted; or
- the day your FMLA leave benefits are exhausted, following the exhaustion of your STD or WCS benefits and any vacation benefits if allowed.

Alternatively, if your employment is terminated while you are receiving STD or WCS benefits, you qualify for benefits under TAP and you continue to be Disabled, you become eligible to apply for LTD benefits; and if approved, your LTD benefit would be effective on the day following your TAP termination date, even though you may not have exhausted your STD or WCS benefits.

Before You Can Receive Any LTD Benefits, MetLife Must Approve Your Claim: Your monthly LTD benefits will begin if MetLife approves your claim, but not before your benefit eligibility date. Any benefits due to you for the period between your benefit eligibility date and the date of your first monthly LTD benefit will be paid to you retroactively in a lump sum with your first monthly LTD benefit. No interest will be paid on the retroactive amount.

Before you receive any LTD benefits, MetLife must approve your claim.

Continued Eligibility For Benefits: Your continued eligibility for LTD benefits is periodically reviewed by MetLife. You must cooperate with, and respond to, requests made by MetLife relating to the review and administration of your claim. If you do not do so, your monthly LTD benefits may be suspended or terminated.

No later than 30 days after the day you are notified that your claim for LTD benefits has been approved, you must apply for Primary Social Security Disability Insurance Benefits and, if applicable, Family Social Security Disability Insurance Benefits, unless you have already done so. If Social Security denies your or your family's claim, you must appeal the denial and continue to pursue the appeal as long as you continue to receive LTD benefits. You may request assistance from MetLife or use your own attorney to pursue a retroactive Social Security Disability Insurance Benefits award. If you do not, your LTD benefits may be suspended or terminated. In determining the amount to be repaid to the plan as the result of a retroactive Social Security award, MetLife may reduce the repayment by reasonable attorney's fees incurred in the pursuit of the appeal.

Additionally, the receipt of any retroactive Social Security or Workers' Compensation award would require an immediate notification to MetLife and a repayment to MetLife of any LTD benefits paid to date that have been duplicated in either retroactive award.

Calculation Of Monthly LTD Benefits: Your monthly LTD benefit amount is based on three factors:

- the LTD coverage option in effect when your STD or WCS benefits end;
- your IASR used to calculate your maximum monthly LTD benefit; and
- your offsets (listed in Table III).

LTD benefits are designed to supplement any offset payments you receive to ensure that your total income from offsets and LTD benefits is no less than 55% or 70% of your IASR.

The IASR used to calculate your monthly LTD benefit is the same as the IASR used to calculate your current annual coverage cost. (Prior to July 1, 2002, the IASR used to calculate the monthly LTD benefit is the greater of your IASR on the day your STD benefits end or the IASR used to calculate your coverage cost.)

"Offsets" are benefits which you are **eligible** to receive from specific sources, such as Social Security and Workers' Compensation while you are Disabled and which reduce your LTD benefit. LTD benefits under the plan are designed to supplement

your offsets to ensure that your total income from offsets and LTD benefits while you are Disabled is no less than 55 percent or 70 percent of your IASR, depending upon whether you have coverage under LTD1 or LTD2. Offsets for which you are eligible will be counted toward your maximum benefits under the plan, whether or not you actually apply for and receive them, so it is important that you apply for any offsets for which you are eligible. Unless you actually receive Social Security retirement benefits or Kodak retirement benefits before age 65, you will not be considered to be eligible for them until you reach age 65.

The following are two examples which compare benefit calculations under LTD1 and LTD2 options:

Example 1: Assume that your IASR when you become Disabled for purposes of the plan is $30,000 per year (or $2,500 per month). Suppose also that you and your dependents are eligible for Social Security disability benefits totaling $1,000 per month, and you are not eligible for any other benefits that qualify as offsets. Your monthly LTD benefit would be $375 under LTD1 and $750 under LTD2.

EXAMPLE 1

	LTD1	LTD2
Maximum Monthly Benefit		
LTD1 (55 percent x $2,500)	$1,375	
LTD2 (70 percent x $2,500)		$1,750
(-) Offsets		
Social Security	-($1,000)	-($1,000)
Monthly LTD Benefit	**$375**	**$750**

Example 2: Assume the same facts as in Example 1, but that, in addition to Social Security benefits, you are also eligible for Workers' Compensation benefits ($1,200 per month).

EXAMPLE 2

	LTD1	LTD2
Maximum Monthly Benefit		
LTD1 (55 percent x $2,500)	$1,375	
LTD2 (70 percent x $2,500)		$1,750
(-) Offsets		
Social Security	-($1,000)	-($1,000)
Workers' Compensation	-($1,200)	-($1,200)
Total Offsets	($2,200)	($2,200)
Monthly LTD Benefit	**$ -0-**	**$100**

Under these circumstances, you would receive no monthly LTD benefit under the LTD1 option because the offsets total more than the maximum monthly benefit. The same is true for LTD2; however, under LTD2 you are guaranteed to receive a monthly LTD benefit of $100 (subject only to withholdings required by law and overpayment deductions) so your monthly LTD benefit under LTD2 would be $100.

All offsets are described below and listed in Table III that follows. Income or benefits you receive from sources other than those designated as offsets will not affect your monthly LTD benefit.

Social Security Offset: Because of delays involved in processing applications for Social Security benefits (old age or disability benefits), you may become eligible for

monthly LTD benefits before you are notified of the outcome of your Social Security claim. In that case, MetLife will estimate what your Social Security benefits will be, and use that estimate as an offset until the actual figure is determined by Social Security. Once you have received a decision on your Social Security application, you must immediately provide a copy to MetLife.

When Social Security notifies you of the outcome of your claim, your monthly LTD benefit will be adjusted to reflect the actual offset. If you were underpaid up to that time (because the estimate of your Social Security benefits was too high), any amount due to you will be paid in a lump sum. If, on the other hand, your monthly LTD benefits were too high, you must repay any overpayment. An overpayment might occur because:

- the estimate of your Social Security benefits was lower than your actual Social Security award; or
- you were paid the full 55 percent or 70 percent of your IASR due to an initial denial of Social Security benefits, and you were later approved for Social Security disability benefits.

If you do not repay the overpayment, your monthly LTD benefits will be withheld and applied to the amount you owe until it is fully paid.

If Social Security denies or approves your claim for benefits, you are required to immediately notify MetLife. Mail a copy of the denied or approved notice to MetLife. If denied, you must file an appeal within 30 days if MetLife determines that an appeal is warranted.

Workers' Compensation Offset: The LTD Plan covers your disability, whether it occurs on or off the job. However, in the case of an on-the-job injury or illness that causes disability, you may be eligible for Workers' Compensation benefits. Workers' Compensation income replacement benefits are considered offsets. If those benefits are paid to you in a lump sum, MetLife will calculate the offset by dividing the lump-sum award by the number of weeks or months that it is meant to compensate you for, and adjust that to a monthly offset figure.

Rehabilitative Employment Offset: While you are Disabled, you may (with MetLife's prior written approval) also receive earnings from non-Company employment intended to help restore you to gainful employment. Such employment may be approved for up to one year and may be extended if circumstances warrant. To encourage rehabilitative employment, an amount equal to only 50 percent of your rehabilitative earnings will be deducted as an offset from your monthly LTD benefit. You must report your rehabilitative earnings to MetLife each month.

Pension Benefit Offset: Generally, your LTD benefits will stop when you reach age 65, normal retirement age. However, you may be eligible to receive both LTD benefits and retirement benefits as stated in the following situations:

- If you elect early retirement while you are an LTD Recipient, and live until the retirement date set forth in your written election, any retirement benefit you receive while on LTD will be offset, thereby reducing your LTD benefit.
- If you qualify for Older Workers' Benefit Protection Act (OWBPA) benefits, because your LTD benefit start date was on or after age 62, refer to Table IV to determine the maximum number of months that your LTD benefits could be paid. Your LTD benefit will be reduced at age 65 by the amount of your retirement benefit, or in the event that you do not elect to receive retirement benefits, your monthly LTD benefit will be offset by the amount of retirement benefits you would have received if you had elected to retire at that time.

If you elect a lump sum retirement benefit under KRIP (whether Traditional KRIP or Cash Balance), the monthly retirement benefit you would have received (if you had elected the straight-life annuity form of payment) will be calculated and treated as an offset.

KRIP is a defined benefit pension plan, so KRIP benefits are offsets and reduce your LTD benefits. However SIP and KESOP are not defined benefit pension plans, so SIP and KESOP payouts are not considered offsets.

TAP Offset: If your employment is terminated due to layoff under TAP while you are receiving STD benefits, and if you subsequently qualify for LTD benefits, any TAP benefit you receive will be an offset. The amount of the TAP offset applied to your LTD benefit will be the gross amount of your TAP benefit before any deduction for offsets required under TAP.

TABLE III: OFFSETS THAT REDUCE YOUR LTD BENEFITS

1. Social Security benefits, including benefits payable to your family as a result of your disability or reaching retirement age.
2. Workers' Compensation income replacement benefits (but not impairment awards, medical reimbursement, and survivor benefits).
3. State disability benefits, whether paid through a company-sponsored plan or otherwise.
4. 50 percent of earnings from any work you do (outside Kodak) in the course of rehabilitation from your disability (rehabilitative employment must be approved by MetLife in advance).
5. Any benefits payable to you under a Kodak-sponsored pension plan.
6. Any TAP benefits for which you are eligible due to layoff (before deducting offsets under TAP).

Adjustments To Monthly LTD Benefits Due To Changes To Your Offsets: Your monthly LTD benefits will be recalculated and adjusted up or down if your offsets change, except in certain situations. For instance, your monthly LTD benefits will be adjusted if your Social Security benefits change as the result of:

- an appeal of a determination made by Social Security;
- an increase or decrease in the number of your dependents who are eligible for Social Security benefits; or
- a cut-back or termination of your Social Security benefits not attributable to any fault on your part.

On the other hand, your monthly LTD benefits will not be adjusted if your Social Security benefits change as the result of:

- a cost of living adjustment; or
- termination of your Social Security benefits due to an act or failure to act on your part (e.g., you refuse to be examined by a physician).

You must notify MetLife within 30 days of any change in your offsets that affect your monthly LTD benefits.

Termination Of Benefits: If MetLife determines that you are no longer eligible for LTD benefits, your benefits will be terminated. In addition, any coverage under the Kodak Medical Assistance Plan, KRx, Kdent, and KLifePlus Basic will terminate along with your LTD benefits.

If you are not eligible because you are no longer Disabled (for reasons other than engaging in gainful work), benefits will terminate after the second monthly LTD benefit payment following the end of your disability. But, your monthly LTD benefits will terminate immediately upon:

- a finding that you are no longer Disabled because you are engaging in gainful work; or
- a determination by MetLife that you have failed to comply with reasonable requests relating to administration of your claim. If such termination was

preceded by a period during which benefits were suspended because of your failure to comply with the reasonable requests, benefits will be considered terminated as of the date the suspension began.

If your LTD benefits terminate for either reason above, you must repay any benefits already paid to you (prorated by day) which relate to the period after termination. For instance, if you receive a monthly LTD benefit of $300 for the month of June, but you engage in gainful work beginning on June 15th through the end of the month, you must repay $150 of the benefit you received.

If your benefit eligibility date occurs before you reach age 62, your monthly LTD benefits will end after payment for the month in which you reach age 65 (i.e., the normal retirement age under KRIP).

If your benefit eligibility date occurs on or after the date you reach age 62, your monthly LTD benefits will end after the month in which you have received LTD benefits for the number of months corresponding to your age on your benefit eligibility date according to Table IV.

TABLE IV

Age As of Eligibility Date	Benefit Maximum Duration Of Benefit Period
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69-74	12 months
75 and older	6 months

LTD Plan benefits stop after payment of the monthly LTD benefits for the month in which you die.

Waiver Of Benefits: If you are eligible for benefits under the LTD Plan, or if you are receiving LTD Plan benefits, and you choose to commence your KRIP benefits, you will be required to waive your rights to any LTD benefits unless you are eligible for early retirement under KRIP. An election to waive benefits is irrevocable. To obtain an LTD waiver form, contact the Kodak Benefits Center.

CLAIMS AND PAYMENT OF BENEFITS

The procedures used by the plan to process benefit claims are detailed in the "Procedures For Plan Claim And Appeals" summary provided later in this handbook. You should review that summary whenever you submit a claim for plan benefits.

Benefits are not paid automatically. Your LTD claim must be submitted to, and approved by, MetLife before you can receive LTD benefits. You will be notified of the process for applying for LTD benefits when your STD or WCS benefits reduce to approximately 16 weeks or less.

The best time to file your claim for your LTD benefits is at least four months before your STD or WCS benefits expire. In most cases, this will allow enough time for your claim to be considered so that, if you are eligible, monthly LTD benefits can begin on your termination date. At this time, or earlier, you should also file a claim for Social Security disability benefits, if you have not already done so.

With your claim for LTD benefits, you will have to supply a report from your physician, and perhaps other documentation of your condition and how it came about. You will also be required to sign a reimbursement agreement stating that you will repay any overpayment of LTD benefits that might occur.

YOUR LTD CLAIM MUST BE SUBMITTED WITHIN ONE YEAR AFTER YOUR STD OR WCS BENEFITS END, OR WITHIN ONE YEAR AFTER YOUR EMPLOYMENT WITH THE COMPANY ENDS, WHICHEVER COMES FIRST.

After your initial monthly LTD benefit payment, benefits are paid to you at the beginning of each subsequent month for which you are eligible. If you have been overpaid any LTD benefits, and you do not repay the overpayment, subsequent monthly LTD benefits will be withheld and applied to the overpayment until it is fully repaid.[3]

Your monthly LTD benefits will be reduced by any amounts required by law to be withheld (e.g., federal income tax withholding), and any amounts necessary to recover a prior overpayment of LTD benefits.

NO ASSIGNMENT OF BENEFITS

Generally, all monthly LTD benefits are paid to you. You may not assign your LTD Plan coverage or benefits. However, if you become physically or mentally incapable of handling your financial affairs, LTD benefits may be paid to another person or institution on your behalf if MetLife is provided with proof that the person or institution has been designated as your legal representative.

TERMINATION OF COVERAGE

Your Eligibility For Coverage Ends: Your LTD Plan coverage automatically ends on the last day you are actively at work immediately prior to the day on which you stop being eligible for coverage for any reason, including (but not limited to) the following:

- the first day of a leave of absence;
- the day your employment ends;
- the day you are transferred to an employment classification that is not eligible to participate in the Kodak Flexible Benefits Program;
- the day you are transferred to an employer that does not participate in the Kodak Flexible Benefits Program; or
- the day you die.

Except as provided in "Termination Of Benefits" under the "Benefits" section above, a LTD Recipient who becomes a Retiree will no longer be eligible for coverage under the LTD plan.

Termination Of Plan: Your coverage will immediately end if the LTD Plan is terminated.

Forfeiture: If LTD Plan coverage ends during a period for which you have paid for coverage, you will not receive a refund of any portion of the coverage cost for which you have already paid.

Other Benefits: LTD Recipients may also be eligible for coverage under other Company-sponsored plans. For details, refer to "Long-Term Disability" in benefit plan summaries that contain such a section.

NO CONVERSION OF COVERAGE

You cannot convert your LTD Plan coverage to individual coverage.

[3] If your monthly LTD benefits terminate before an overpayment is repaid to the plan, the plan has the right to pursue legal action to recover the amount overpaid from you, your legal representatives or your estate.

LEAVE OF ABSENCE

Your plan coverage stops while you become an LOA Employee or Educational LOA Employee. Your plan coverage will start again on the first day you are actively at work as an eligible Employee after your leave of absence ends. For more information, contact the Kodak Benefits Center to request a leave of absence package specific to the type leave you are considering.

PLAN IDENTIFICATION

The Kodak Long-Term Disability Plan is sponsored and maintained on a self-insured basis by Eastman Kodak Company, 343 State Street, Rochester, NY 14650-1112. Kodak's Employer Identification Number, assigned by the Internal Revenue Service, is 16-0417150. The plan number, assigned by Kodak, is 532. The plan was established and is effective as of January 1, 1993, and has been changed from time to time. This benefit summary reflects the terms of the plan in effect at the time of publication unless otherwise specified. Financial records are maintained on a calendar year basis with each plan year ending December 31.

As a self-insured plan, LTD Plan benefits are paid from the general assets of Eastman Kodak Company. MetLife assists in the administration of the plan under an administrative services agreement with Kodak. In accordance with that agreement, MetLife acts as the claims administrator, performing such duties as reviewing claims for the purpose of approving, adjusting or denying benefits, and issuing benefit payments.

By law, the Kodak Long-Term Disability Plan is classified as an employee welfare benefit plan providing disability benefits. The plan administrator is the Director, Worldwide Benefits, located at the above address (telephone: 585-724-4800). However, if you have questions or concerns about the plan, you are urged to first call the Kodak Benefits Center.

The plan administrator is the designated agent for service of legal process. Legal process may also be served on the Metropolitan Life Insurance Company at One Madison Avenue, New York, NY 10010.

Plan Document Controls: If there is a conflict between this plan's benefit summary and its plan document, the plan document will control. See the "General Plan Information" summary at the beginning of this handbook part to find out how to get a copy of the plan document.